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## Notice of Independent Review Decision

### **IRO REVIEWER REPORT**

**Date Amended: November 29, 2016:**

**IRO CASE #:**

### **DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Thoracic Facet Block at the bilateral T5 and T6 Medial Branch of Dorsal Ramus with Fluoroscopy and Anesthesia

### **A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:**

This case was reviewed by a board-certified Physical Medicine and Rehabilitation who is considered to be an expert in their field of specialty with current hands on experience in the denied coverage.

### **REVIEW OUTCOME:**

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

**Upheld**

### **PATIENT CLINICAL HISTORY [SUMMARY]:**

This claimant sustained injury on XX/XX/XX to multiple body areas when XXXXXXXX. He reported injury to his neck, back, upper back, right leg, and right foot. Regarding the thoracic spine, he has been consistently diagnosed with thoracic sprain, no radiculopathy. MRI of thoracic spine dated XX/XX/XX showed approximately 6 mm disc herniation at T8-9 creating moderate stenosis of the entry zone of the left neural exit foramen. Smaller disc herniation was noted at multiple other levels at T6-7, T7-8, and T9-10. At XX's exam dated XX/XX/XX for MMI/Impairment Rating, thoracic strain was diagnosed without evidence of focality at any level (facets or radiculopathy). XX on XX/XX/XX also diagnosed him with thoracic strain without evidence of focality at any level (facets or radiculopathy). XX evaluation

dated XX/XX/XX showed the patient presented with upper back and neck pain. The pain does not radiate. On exam there was facet pain on spine rotation/extension/flexion and palpation in the thoracic region at the bilateral T5-T6 level, pain on palpation at the bilateral T5-T6 facet levels. XX diagnosed with strain of muscle and tendon of back wall of thorax, subsequent encounter and recommended thoracic facet block at T5-T6 medial branch of the dorsal ramus bilaterally. If successful, RFA with physical therapy was recommended.

**ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:**

As per the ODG (Official Disability Guidelines), the criteria for the use of diagnostic blocks for facet “mediated” pain includes: Clinical presentation should be consistent with facet joint pain, signs & symptoms. This claimant neither has the MRI findings at the proposed level T5-T6 remarkable for facet hypertrophy or physical findings consistent with facet joint tenderness at the site of the proposed level at T5-T6. Facet injections would not be indicated for the diagnosis of thoracic strain at any level of the spine without specific facet joint pain at that level. XX has recommended RFA with PT if it is successful. In particular, the ODG indicates thoracic joint injections are not recommended because there is limited research on therapeutic blocks or neurotomies in this region, and the latter procedure (neurotomies) are not recommended. ODG further states “recent publications on the topic of therapeutic facet injections have not addressed the use of this modality for the thoracic region. Pain due to facet joint arthrosis is less common in the thoracic area as there is overall less movement due to the attachment to the rib cage. Injection of the joints in this region also presents technical challenge.” Thus, the previous denial is upheld.

**A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:**

**ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

**Low Back - Lumbar & Thoracic (Acute & Chronic)**

**Facet joint injections, thoracic**

Not recommended. There is limited research on therapeutic blocks or neurotomies in this region, and the latter procedure (neurotomies) are not recommended. Recent publications on the topic of therapeutic facet injections have not addressed the use of this modality for the thoracic region. (Boswell, 2005) (Boswell2, 2005) Pain due to facet joint arthrosis is less common in the thoracic area as there is overall less movement due to the attachment to the rib cage. Injection of the joints in this region also presents technical challenge. A current non-randomized study reports a prevalence of facet joint pain of 42% in patients with chronic thoracic spine pain. This value must be put into perspective with the overall frequency of chronic pain in the cervical, thoracic and lumbar region. In this non-randomized study, 500 patients had 724 blocks. Approximately 10% of the blocks were in the thoracic region, with 35.2% in the cervical region and 54.8% in the lumbar. (Manchikanti, 2004)

**Facet joint diagnostic blocks (injections)**

Criteria for the use of diagnostic blocks for facet “mediated” pain:

Clinical presentation should be consistent with facet joint pain, signs & symptoms.

1. One set of diagnostic medial branch blocks is required with a response of  $\geq 70\%$ . The pain response should last at least 2 hours for Lidocaine.
2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally.
3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks.
4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels).
5. Recommended volume of no more than 0.5 cc of injectate is given to each joint.
6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward.
7. Opioids should not be given as a “sedative” during the procedure.
8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety.

9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use and activity logs to support subjective reports of better pain control.
10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005)
11. Diagnostic facet blocks should not be performed in patients who have had a previous fusion procedure at the planned injection level. [Exclusion Criteria that would require UR physician review: Previous fusion at the targeted level. (Franklin, 2008)]

#### **Facet joint intra-articular injections (therapeutic blocks)**

Criteria for use of therapeutic intra-articular and medial branch blocks, are as follows:

1. No more than one therapeutic intra-articular block is recommended.
2. There should be no evidence of radicular pain, spinal stenosis, or previous fusion.
3. If successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive).
4. No more than 2 joint levels may be blocked at any one time.
5. There should be evidence of a formal plan of additional evidence-based activity and exercise in addition to facet joint injection therapy.